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Labyrinthine Reimbursement for Hearing Aids

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1

Disclosures

- Employer (salary): University of Miami
- Florida Chapter American Academy of Pediatrics (honorarium)
- New Jersey Speech and Hearing Association (honorarium)

- No non-financial disclosures to report

2



Learning Outcomes

After this course, participants will be able to:

- Identify benefits and constraints of insurance/HMO reimbursement for hearing aids and related services.
- Execute appropriate procedures to discover coverage policies established by Medicaid agencies, insurers, and HMOs.
- Identify the most appropriate charge/reimbursement model for each respective practice in addition to the impact of imposed charge/reimbursement models.

3



Ah, the Good Old Days...

- Commercialization of hearing aids began in the 1950s
- Individuals went through factory training to become “Hearing Aid Dealers”
- Franchises (exclusive distribution contracts) were common to offer one brand only
- Hearing aid selection based primarily on pure tone testing
- Purchases were cash or contract

4

Bundled Price Model

- Separate reimbursement for hearing testing versus device sale did not exist.
- Price was set according to manufacturer's suggested retail price
- Price could be adjusted (somewhat)
- Calculation of cost of service was not a consideration
- No need for office staff for insurance payment

5

Technology of the 1950s

- Introduction of transistors replacing vacuum tubes
- Key players:
 - Raytheon
 - Bell Laboratories
- Early brands:
 - Siemens
 - Acousticon
 - Maico
 - Beltone



6

Technology of the 1960s

- Zenith realized a problem with the previous decade technology
 - Transistors were sensitive to body heat
 - Hearing aids lasted only a few weeks
- Zenith introduced a “better” transistor hearing aid in the 1960s based, in part, on the space program technology
- Adjustments were made by potentiometers for frequency and MPO
- Much of the “fitting” consisted of guidance counseling on maximizing use.
- 1967 audiologists publish a criticism of hearing aid dispensing

7

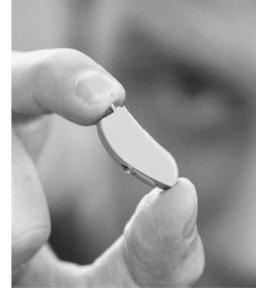
Medicare and Medicaid

- Social Security Act modified in 1965 to include insurance-type medical benefits for “elderly” (Medicare) and “poor” (Medicaid)
- Audiology was placed in a benefit category of “Diagnostics Only”
 - Hearing aids forbidden due to perspective of being “optional”/cost
 - Audiology was working to establish, expand, and legitimize its employment activities:
 - Clinical / diagnostic audiology
 - Teaching
 - Auditory rehabilitation
 - Audiological research
- Employment: Physicians and community speech/hearing centers

8

Events of the 1970s and 1980s

- Other seminal events:
 - AMA began development of CPT codes in mid 1960s
 - Number of CPT does filled two pages (typewritten) and mimeographed (copied)
 - Early 1970s audiologists begin dispensing
- Hybrid hearing aids (digital controller and analog amplifiers) (1970s)
- Fully digital hearing aids began their introduction in the 1980s
- Hearing aid selection was based on comparison of instruments



9

Medicare Influence of the 70s / 80s

- Medicare paid the price of the diagnostic hearing test to audiologists or to physicians via “incident to” billing
- Payment conditions:
 - Provided by a “qualified” audiologist
 - Medical necessity (not previously diagnosed; change in status; new symptoms)
 - Testing not for the sole purpose of purchasing a hearing aid
- Audiologists performed the test and the “hearing aid evaluation”
- Individual was sent to a “trusted” hearing aid dealer with a prescription for make/model of hearing aid

10

Medicaid Coverage of Hearing Aids (Adults)

- Medicaid is a federal/state program whereby the fed has created a framework, but state legislatures decide which “optional” benefits to offer.
- Adult hearing aids are under the optional benefit category that is not mandated by Medicaid.
- No uniformity from one state to another with regard to:
 - Eligible hearing loss level
 - Coverage pricing (hearing aid and dispensing fee)
 - Replacement period
 - Follow-up payments (e.g., “Conformity Visits)

11

Medicaid Coverage of Hearing Aids (Children)

- Major difference between adults and children: EPSDT
- Coverage of hearing aids and therapies are mandated for children
- Payment is based on legislative allocations and not any particular formula
- Often, device and accessory payment is a pass-through whereby reimbursement is directly related to the wholesale cost
- No difference in reimbursement between child and adult for diagnostic or hearing aid services

12



State Legislative Medicaid Accountability

- Medicaid occupies a significant portion of each state's general revenue fund
 - Florida tends to run between 25-30% of state budget
 - 52% of Florida births are Medicaid
- Conservative legislative bodies have worked to shift cost risk to private HMO firms
 - Utilization management review companies subcontracted to HMOs
 - Management review responsible to HMO / HMO responsible to MCD agency
 - Intended to cover all services including audiological services
 - Designed to control or limit access to services for \$ savings

13



MCD Utilization Management Review Entities

- Must follow all eligibility rules of regular Medicaid
- Not required to maintain Medicaid reimbursement prices
- May be statewide entity (with audiology network) or specific to a single HMO
- Can add to the Medicaid eligibility rules as long as it doesn't restrict access to services
- Noteworthy: hearing loss eligibility criteria vary from state to state
- Access limited due to reimbursement

14

Access to Hearing Services

- Public perception of cost, benefit, and availability
- Influenced by:
 - Bundled pricing (commodity)
 - Insurance coverage
 - Peer comments
 - Governmental reviews
 - Pricing models
 - Physician comments

15

Access to Hearing Services

- Legislative mandates for hearing aid coverage:
 - ~23 states of a legislative mandate for insurance / HMO coverage of hearing aids
 - Maximum eligibility age ranges from 18 years (Georgia) to 24 years (Delaware) through adulthood
 - Replacement period: 36 to 48 months
 - Coverage amount: \$1000-\$3000 (\$4000 in Oregon)
- In states with no legislative mandate:
 - Less insurance coverage and payment
 - Coverage for children may vary from max age of 12 months through 18 years

16

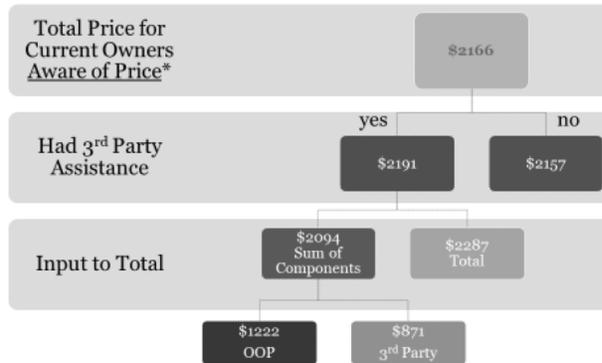
Out of Pocket Costs

The average HA price per hearing aid among owners is just under \$2200, and it varied little by whether or not they had 3rd party assistance.

86

***Process for estimating price:**

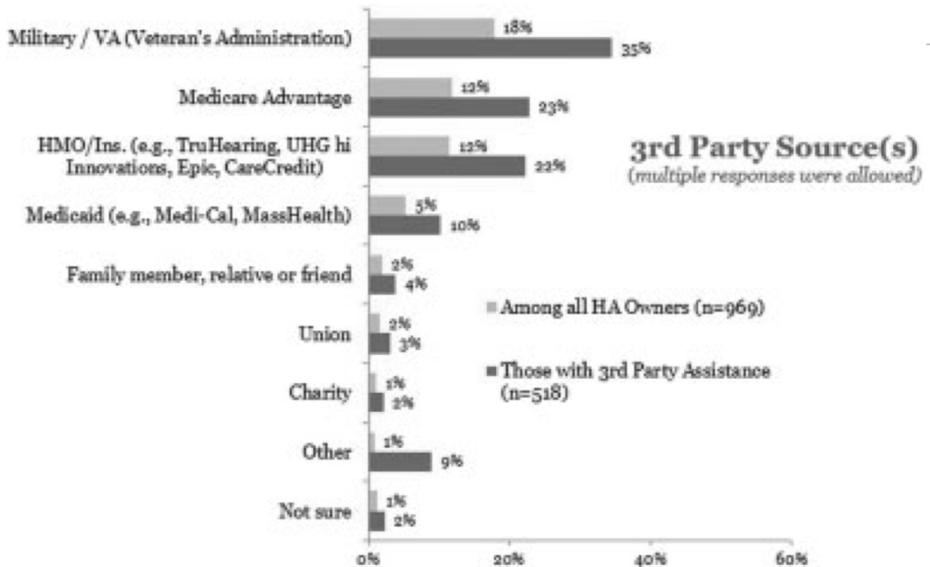
- Asked for components prices if had 3rd party assistance (out of pocket \$ they paid and \$ paid by 3rd party/parties).
- Asked for total price if not sure of both component prices.
- Asked for total price if had no assistance.
- Computed a total for all with sufficient input.
 - Computed a mean applying a "valid" range: \$500-5500 range (to exclude the most extreme outliers (e.g., people who misunderstood the question, listed the price for a pair, only listed the \$ they were responsible for, etc.)).
 - 79% of initial total prices were within the valid range (n=484), which is the base shown.
- NOTE: The rest were unaware of components and/or total or had an outlier value.
- This series was also asked of non-owners who returned or got rid of hearing aids they owned in the past:
 - These past owners had an average of \$1607 (n=60).
 - The average price for those who ever owned (current, past owners) is \$2114 (n=544).



(MT10 Report - 3/27/2019 - HIA Members)

17

Third Party Assistance



18



Models of Hearing Aid Dispensing: Contracted Provider Network (variation 1)

- Each audiologist is contracted with a corporation serving as a provider network
- Statewide or regional offices carrying the name of the corporation
- All audiologists and support staff are employees of the Corporation
- The Corporation contracts with healthcare companies and may receive a capitation rate for all provided services
- Audiologists are encouraged to provide services to customers apart from any contracted healthcare entity

19



Models of Hearing a Dispensing: Contracted Provider Network (variation 2)

- A variation of the contracted provider network allows the audiology practice to remain independent
- The practice contracts with the corporate entity to receive referrals linked to a healthcare insurer
- Brand selection, pricing, and reimbursement are fixed and limited in some cases
- There may be practice restrictions on how evaluations are performed

20



Models of Hearing Aid Dispensing: Hybrid Contracted Network

- The audiologist/practice contracts with a national firm for administrative and hearing aid purchasing options
- The Corporation provides assistance with marketing, financial monitoring, human resources, billing and coding, and business development
- Requires a membership subscription and attempts to save money for each practice by reducing fixed overhead costs
- Fewer restrictions than a contracted provider network
- Sales and reimbursement not linked to ensure HMO or HMO
- Proceeds come directly into the practice

21



Models of Hearing Aid Dispensing: Cooperative Network

- A defined financial investment is required of each practice for stock in the co-op
- Each practice has a vote to elect a Board of Directors
- Board's responsibility: increase efficiency of each practice, access to marketing and media outlets, administrative support or staff training
- Share overhead expenses with reduced overall cost to each practice
- Greater negotiating influence for purchasing discounts
- Practice profits minus overhead and shared expenses go directly into each practice

22



Models of Hearing Aid Dispensing: Simple Purchasing Co-Op

- Independent practices band together to establish volume purchase discounts
- Reduced wholesale costs
- Increased profitability and price competitiveness
- No central administrative organization
- No benefits beyond bulk purchase discounts

23



Balance Billing for Hearing Aid Purchase

- Balance billing is sometimes possible with insurance and HMO coverage, **but there are exceptions**
- The audiology practice must have a copy of the contract between the practice and the insurer/HMO/provider network
- Note: the finalized contract is not always shared with the audiology practice
- The contract should stipulate the scope of services, billing policies, and code selection

24

Bundling Versus Unbundling

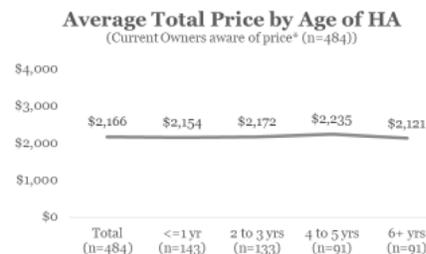
- Healthcare transparency as focused upon hearing services in recent years
 - President's Council of Advisors on Science and Technology (PCAST)
 - National Academies of Sciences, Engineering, and Medicine (NASEM)
- Bundling the price of evaluation, instrument, and professional services has created a perception of unaffordable access

Total Price of Hearing Aid

The price per hearing aid varied across the owners, but the average total price has been fairly stable over the past several years.

87

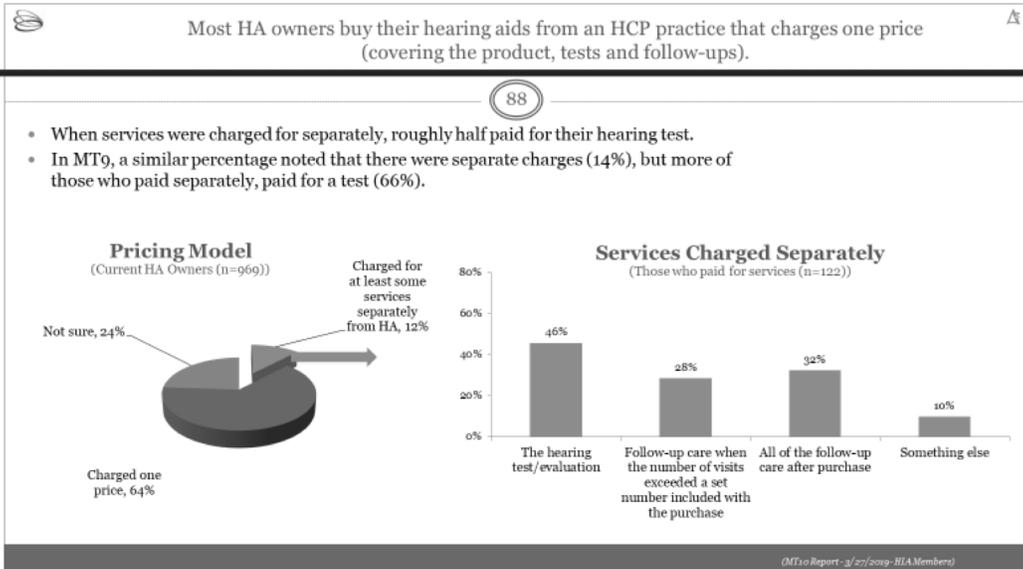
- The average price paid by current owners has hovered around \$2,200 for the past 5 years.



*Prices used were all within the "valid range" defined earlier.

OMT's Report - 3/27/2019 - HIA Members

Total Price of Hearing Aid



27

Influences on Unbundling

- Medicaid typically requires unbundling of the hearing test versus instrumentation versus dispensing
- In some states, mandates on refunds take into account the separate charge for the diagnostics
 - Bundle charge can complicate professional services versus instrument refunds following a trial period
- Greater involvement of insurances and HMOs has trended toward unbundling to various degrees
- Payment for dispensing versus aftercare professional services

28



Transparency in Pricing

- In consideration of the PCAST and NASEM reports there is a strong desire for transparency in hearing service pricing
- Many different formulas for unbundling
- Major point: unbundling helps the consumer understand how the hardware versus professional service contribute to total cost
- However, there are occasions determined by insurance coverage or geography when unbundling is not appropriate
- The bottom line cost to the consumer should be the same whether bundled or unbundled
- Appropriate, justifiable pricing should be based on the cost of service delivery and product handling

29



Establishing Price Points

- Determination of charge levels depend on:
 - Cost of service delivery
 - Percentage mark-up for profit / cash reserve
 - Overall insurance reimbursement and whether balance billing allowed
 - Cost shifting principal when balance billing not allowed
 - Examination of overall reimbursement
 - Medicaid
 - HMO
 - Indemnity insurance

30

Looking to the Future...

- OTC and PSAPs offer new opportunities for audiology to return to its roots
- Audiology began as a rehabilitation profession
- The original focus was maximizing use of residual hearing
- Auditory rehabilitation required extensive counseling and listening to establish a trusting relationship in guiding the patient
- OTC and PSAPs portend to have great influence over the clinical practice of audiology
 - Sales of the instrument may decrease but professional services may increase
 - Charge calculations must be based on cost analysis of service delivery



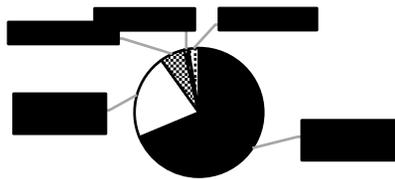
Across all amplification product owners, there is a notable level of respect for the role of the hearing care professional.



32

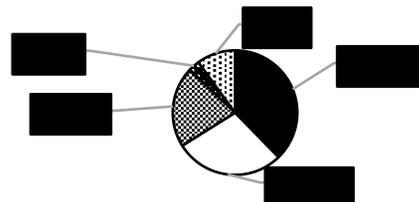
- HA owners almost unanimously agree that the HCP they worked with played a substantial role in their journey with hearing aids.
- Almost two-thirds of PSAP owners suspect they would have benefited from some professional help along the way.

How much did the HCP help? (Current HA Owners (n=960))



Question for HA Owners:
Given your experience working with a hearing care professional during the process of selecting, getting used to and using your hearing aid(s), how much, if at all, did they help you along the way?

How much would you have benefited from having HCP help? (Current PSAP Owners (n=193))



Question for PSAP Owners:
Given your experience selecting, getting used to and using your hearing device or personal amplifier, that you got directly, on your own, how much, if at all, do you feel you would have benefited from having a hearing care professional help you along the way?

Concluding Thoughts

- Much has changed since hearing aids were first sold 60+ years ago
- Increase in knowledge and capability regarding:
 - Physiological causes and effects of hearing loss
 - Hearing aid capabilities
 - Cochlear and auditory central nervous system function
 - Fixed overhead cost of administrative support
 - The influence of insurance/HMO reimbursement
 - Self purchase of OTC hearing aids and PSAPs
- **We do live in interesting times!**

33

Thank You!

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34